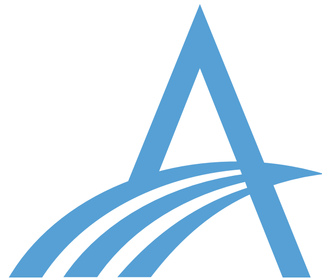

Academy of General Dentistry™

INVESTIGATIVE REPORT ON THE CORPORATE PRACTICE OF DENTISTRY

Prepared by:

Academy of General Dentistry

Practice Models Task Force

2013

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I. PREFACE

What is corporate dentistry? How do corporate models of dentistry vary from solo practice corporations, small group practices, or other large group practices? Are all models of corporate dentistry the same? Will corporate models continue to grow, or have they reached a plateau?

Many have heard the term "corporate dentistry," but few understand its vast spectrum of definitions and implications. Recognizing the need for dentists to be better informed, the Academy of General Dentistry (AGD) responded in 2012 by launching an investigation into corporate models of dentistry.

II. EXECUTIVE SUMMARY

The AGD's "Investigative Report on the Corporate Practice of Dentistry" presents an accurate and objective review of the AGD Practice Models Task Force's findings, attained through a year of interviews with various corporations' current and former executives and staff, as well as a review of multiple documents, from depositions to articles.

Contemporaneously with but independently from the work of the AGD, Sen. Max Baucus (R-Mont.), chairman of the Committee on Finance, and Sen. Chuck Grassley (R-Iowa), ranking member of the Committee on the Judiciary, developed the "Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program" (June 2013), which asked whether short-term profits come at the cost of quality care and a sustainable business model in the long run.

While the senators focused primarily on a single corporation as it relates to the service of Medicaid patients, based largely upon a response to whistleblower complaints, certain elements of the joint staff report nonetheless underscore the importance and timeliness of this subject matter. Specifically, the report highlights the need for a deeper understanding of the various corporate dentistry business models.

Corporate dentistry refers to any of a variety of practice modalities in which management services, at a minimum, are provided in a manner that is organizationally distinct from the scope of activities performed by a dentist within only his or her practice. Depending upon the model, dental management companies, dental service organizations (DSO), management service organizations, and/or dental management service organizations (DMSO) provide or administer management services. A more detailed definition of "corporate dentistry" and other terms are provided in Section V.

One model of corporate practice utilizes practicing dentists as shareholders who develop and implement business functions and expectations.

Another model uses professional corporations—sometimes one per state, and sometimes many per state or one per many states—with oversight over multiple practices and the responsibility of administering business services and expectations of outside owner(s) through business services contracts.

While some models use outside owner(s) that are not investors or equity firms, other models do use such outside owners. While the former may base profits primarily on a percentage of actual net revenue of contracted dental practices, the latter also may base profitability on Wall Street valuations, including the use of the present value of future expectations of gross receipts to paint the business as a more lucrative opportunity for prospective investors.

Ultimately, the growth of corporate models may vary based upon the priorities of up-and-coming generations of dental school graduates, as well as the effects of the Patient Protection and Affordable Care Act of 2010 (PPACA) and the varying and continually changing structures and contracts of DSOs. While some economists expect continued growth of large group practices, including models of corporate dentistry, others predict that the market share of corporate models has reached a plateau or will reach a plateau at or about 20 to 25 percent of all practice modalities.

While this investigative report does not engage in predictions or speculation, the findings indicate that using zealous Wall Street valuations for short-term outside investor profitability could result in a market bubble that may burst under its own weight.

This does not mean that any one model of corporate practice is a better or worse option for new graduates or established dentists than any other. American Dental Association (ADA) surveys indicated numerous reasons for considering various models of practice, including work-life balance, interactions with other dentists, flexible schedule, guaranteed salary, and less interaction with insurance companies; the need to repay student loans was not noted as a significant reason. It does mean, however, that dentists who are considering varying models in which to practice must understand how different corporate models work.

This investigation revealed that, while dentists ask questions, many do not ask the right questions. Dentists, especially new graduates, often ask what their hours might be or how much they might get paid. However, interviews indicated that dentists are not asking but should ask the following questions, among others:

1. Who is my employer?
2. Who can create or edit a treatment plan? Who is responsible for the treatment plan? Do I have the authority to disagree with or change a treatment plan?
3. Who owns the dental professional entity? Who owns the business entity?
4. What is the governance structure of the dental professional entity? Of the business entity?
5. Does the business entity have a relationship with any outside investors, such as an equity firm or public company?
6. Is there a management services agreement? If so, does that agreement comply with state laws?
7. What are my employer's expectations regarding my productivity, patient volume, and revenue? For example, may I take two hours to complete a crown prep?
8. What formula is used for dentist compensation? That is, to what degree is my remuneration based on my productivity?
9. What is the relationship between my compensation and that of the business entity?
10. Who owns the lease agreements for the building? For the equipment? If I buy a practice, will I have the opportunity to own the equipment in full, or will I rent the equipment perpetually? If I can own the equipment, what is the lease term, and is there a separate agreement for a lease-to-own opportunity?
11. May I use any vendor for supplies? Is there a cap on the volume or type of supplies available?
12. May I use a dental laboratory of my choosing? How are lab costs ascertained and apportioned?
13. Who has control over revenue stream distribution, and how is the revenue stream distributed?
14. Who owns patient records? Upon termination, would I have access to patient records? If so, to what extent? Is there a procedure for accessing these records?
15. How are after-hours emergencies addressed?
16. Who makes hiring and firing decisions? Are there any protocols or guidelines for these decisions?
17. May I have access to all contracts and other documentation upon which the above answers are based, so that I may share them with an independent attorney, accountant or professional adviser?

Ultimately, the findings indicate that each dentist must access the information necessary to determine whether management services could impinge upon his or her ability to exercise his or her professional clinical judgment, and to comply with the ADA Principles of Ethics and Code of Professional Conduct, as well as state and federal laws and regulations.

Regardless of who holds the responsibility for business decisions, dentists hold the responsibility for their clinical and ethical decisions, whether before a state dental board, a court of law, or the court of public opinion.

Therefore, the findings suggest that all dentists, from new graduates to established practitioners, should gather the necessary information and consult with their own independent attorney or accountant, or another professional who is familiar with the various modalities of business practices in health care delivery, before making a career decision—regardless of which practice modality they are considering.

Dentists also may contact their professional advisers for further information or contract review.

III. A CHANGING ENVIRONMENT

For centuries, medical professions have placed patient welfare ahead of financial success.

Historically, dentistry has been practiced in offices owned by one or a few dentists, who hold direct responsibility for both patient care and business management.

Today, we are finding that some economic and social factors are leading to an increase in the corporate modality.

While findings indicated that other factors may drive dentists' employment and ownership decisions more than student loans, it is nonetheless noteworthy that the average cost of a dental education has doubled from 2000 to 2010, from $121,434 to $216,842 for a nonresident and from $84,819 to $158,119 for a resident.[1] Concurrently, decreased utilization of oral health care services, preceding and exacerbated by the Great Recession of 2009, has decreased opportunities for graduating dental students to find employment opportunities in traditional solo or small group dental practices and, more so, in underserved areas while staying current with student loan payments. Decreased utilization and low Medicaid reimbursement, among other factors, also have challenged the survival of existing dental practices and contributed to maldistribution of dental practices.

Dental management companies have found opportunity in this situation by offering business models designed to enable dentists and new graduates to earn living wages while providing clinical care to a variety of population groups. These various business models are sometimes referred to, broadly, as the corporate practice of dentistry, or corporate dentistry.

The question that arises, then, is whether any business models, actions, or contractual agreements of dental management companies could adversely impact the clinical aspects of the practice of dentistry, the doctor-patient relationship, and ultimately the care given.

While examining this inquiry, one must be mindful of several factors.

First, regardless of the business model, action, or contractual agreement, the practicing dentist has the ultimate responsibility to practice ethically in accordance with his or her state's laws and regulations, including its dental practice act.

Second, at this time, there is no universal agreement regarding the terminology and definitions for the various business models associated with management companies. Therefore, the definitions provided here are for reference and understanding of the terms used in this paper, and not necessarily applicable outside the context of this report.

Third, the findings encapsulated herein reflect a snapshot of the current environment of practice modalities. However, this environment continues to be in flux, with numerous variations in practice modalities and with the largely unknown and unpredictable consequences of the PPACA's implementation, including the establishment of health care exchanges and accountable care organizations (ACO).

Fourth, in light of this changing environment, the business models and terms of their contractual agreements may vary over time, location, company, and other factors.

Fifth, this investigative report is not intended to identify or opine upon the practices of any one company as compared to any other. This investigative report is not presented as a policy or position of the AGD. Rather, the paper offers findings based upon the investigations of the AGD Practice Models Task Force.

IV. PROCESS OF INVESTIGATION

After preliminary research of existing online literature, the AGD Practice Models Task Force held its first meeting, Dec. 7 and 8, 2012; its second meeting May 31 and June 1, 2013; and a final development meeting on Aug. 2, 2013. The task force interviewed executives and other business representatives of six management companies that presented six different management models, labeled A through F in Section VII below.

Additionally, the task force interviewed representatives of other alternative practice structures, as well as a number of individuals now or formerly associated with corporate entities, including those marked as A through F in Section V. These individuals indicated that they were speaking on their own experiences. They included a dentist currently employed as a dental director for a corporation, a former dental director for a corporation, a dentist owner of a professional corporation (PC) contracted with a corporation, and a former corporation employee, as well as an executive of an affected vendor and an attorney engaged in litigation against a corporation. The attorney also provided two depositions and other information, which was reviewed by the task force. The task force also reviewed the "Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program" issued by Sens. Baucus and Grassley, as well as public documents related to North Carolina litigation, redacted briefs from other litigation, and numerous other articles and reports.

The findings presented here provide a compilation of the information gathered via literature review and interviews, as set forth above.

V. DEFINITIONS

Efforts to define corporate dentistry terms are ongoing via other organizations, including the ADA. Nothing in this section is intended to conflict with the findings of the ADA. Ultimately, it would be beneficial for the dental profession to arrive at a common understanding of terms in the fields of corporate practice, to ensure optimal dialogue on related issues.

Corporate dentistry: For the purpose of this report, "corporate dentistry" is used to refer to any of a variety of practice modalities in which management services, at a minimum, are provided in a manner that is organizationally distinct from the scope of activities performed by a dentist within only his or her practice. Categories of corporate practice are elaborated further in Section VII. In many but not all cases, corporate dentistry refers to practice modalities in which practice services are provided via a contract with a third-party organization that is not controlled by the practicing dentists. Further, in many cases, that organization is funded by the investments of for-profit entities that are not directly engaged in the clinical practice of dentistry and not necessarily dentists. "Corporate dentistry" is sometimes used synonymously with managed group practices, and the management organization may be referred to as a dental management company or dental service organization (DSO). With structures that utilize a contract between a group practice and a third-party organization for management services, the group practice may be referred to as the DSO, and the management organization may be referred to as the management services organization (MSO), and the modality of this practice and business structure may be referred to as a MSO/DSO or dental management services organization (DMSO). However, many refer broadly to all these variations as simply DSO. As noted earlier, universality in the terminology in this field has not yet been achieved.

1. American Dental Association, Survey Center, Surveys of Dental Education (Group II, Question 15a)

Dental director: The dental director, responsible for quality assurance in at least one model of corporate dentistry, may be an employee of the DSO and/or the director of a PC that has a business service agreement with the MSO. Dental directors may not always be dentists. Those dental directors who are dentists are not always licensed in all the states in which they function.

Dental practice ownership: References to dental practice ownership by DSOs generally refer only to patient records and not to dental equipment or the building in which the practice is housed.

Earnings before interest, taxes, depreciation, and amortization (EBITDA): EBITDA is gross revenue minus expenses, excluding interest, taxes, depreciation, and amortization. Sometimes, equity firms that invest in DSOs may use EBITA instead of EBIDTA, leaving in depreciation as an estimate of the annual cost of replacing a firm's fixed assets. For a further discussion of evaluation methodologies for businesses, please see Section VI below.

Equity firm: In this context, equity firms refer to firms that raise capital for DSOs, often provide representation on the board of DSOs, and receive a share of profits produced by DSOs. In this context, the task force explored how various models balance the pure financial interests of equity firms with the ethical obligation of practicing dentists.

Professional corporation (PC): Often the structure of choice for dentists, physicians, attorneys, and other professionals, the PC offers many of the protections of incorporation but maintains the personal malpractice liability of each professional without causing the corporation or the other professionals to bear the burden of that liability. In some corporate dentistry models, the DSO enters into one or more business services agreements with one or more PCs in each state, whereby each PC claims to be owned by dentist(s) licensed in the state and includes the dental professionals of one or more dental practices. Generally, it appears that the DSO purchases the dental equipment and building and leases both back to the PC, while the PC retains ownership of the "dental practice," i.e., the patient records. However, the actual control of the PCs varies widely in corporate models.

VI. BUSINESS VALUATION METHODOLOGIES

Evaluating a DSO is not fundamentally different from evaluating other businesses; however, because a DSO is engaged in providing irreversible health care services, public safety must be part of the assessment. While public safety is difficult to quantify, it can be assessed loosely by the organization's objectives, its mission, and the market pressures it will experience. Market competition should be secondary to patient safety.

Several approaches are commonly used to assess a business. One approach evaluates the total assets of the firm in relation to the total liabilities. This is sometimes called the book value of the business; it is analogous to the net worth of an individual. This measure applies to a point in time but can change over time.

A second approach is the market value approach. This approach is often used to assess real estate, such as residential homes. For example, a home that cost $500,000 to build may be assessed for tax purposes at $800,000 several years later and put on the market with an asking price of $825,000. If the highest bid for the home is $740,000 and no other bids come in, then that is the market value of the home, and the owner must decide whether to accept the bid or keep the home.

A third approach is the balance (profit) sheet approach. This approach evaluates the earnings of a business less its costs of operation over a period, usually a fiscal year. As part of that approach, accountants use the EBITDA measure.

The ITDA deductions are critical for tax purposes and included in the information public corporations are required to provide to the Securities and Exchange Commission (SEC). However, they are not very good indicators of the value of the large group practice organization from an economist's (or a market value) point of view.

Both EBITDA and EBITA are determined with the following accounting procedures.

The process starts with the gross sales of a business enterprise. This is simply the number of units sold multiplied by the price of each unit. For a dental practice—whether it's independently owned with only one primary practice location, a small partnership, or a professional corporation—gross sales (billings) are calculated by recording every chargeable service provided by the fee for each service. This is generally identical to the total expenditures for all the patients that the practice has serviced and charged for services.

The next step is total net operating income. The net operating income of a solo practitioner is simply gross earnings from his/her practice minus operating costs. Usually, solo practitioners will include interest paid on loans and depreciation/amortization of costly durable equipment in operating costs. They also include office space rent (or mortgage), utilities, and maintenance. Renewable supplies and acquisition of new equipment are also part of operating expenses, although larger organizations sometimes place the latter in a capital budget. These are non-labor (not staff-related) expenses.

The major component of most independent practitioners' operating costs is labor (staff-related) expenses. This also applies to large DSOs. Labor costs include staff salaries and fringe benefits. After these expenses are deducted from gross earnings (collected billings), the remainder is usually called the net income of the practice (DSO). Because a small independent solo practitioner keeps the net income of the practice, that net income is an item of income on his/her tax returns, usually under a Schedule C form, in addition to any other sources of income that are included in the final tax return, as well as non-practice-related deductible expenses. The practitioner's tax burden is based on that final number.

The balance sheet approach provides an evaluation for one accounting period. To evaluate the value of a business, including a DSO, it may be necessary to project a stream of income over a future period of years. An inflation factor would be included to calculate the evaluation of all of these future incomes. Since prices and cost of living change over time, it is necessary that future income streams be discounted to a present value. This is done by assuming that future income streams will probably increase in value due to inflation. They are decreased to the present value through applying a discount rate. The size of the discount rate is chosen based on the investor's time horizon and his or her assumptions about future prices.

Calculating a present value based on future income streams is a way to compare two income streams over time. Assumptions regarding the future incomes go into those present value calculations. If those assumptions prove incorrect, the present value on which they are based also will be incorrect. These same balance sheet principles apply regardless of whether the business is a dental organization or a nondental organization.

Present value is not necessarily equal to the market value. The person who buys the practice must consider how much of its existing clientele will stay with the new ownership. The buyer also must gauge the local competition and the potential growth of the local market.

This takes us to the third approach for assessing the economic value of a business: the market evaluation approach. Several factors play a role in this approach.

If the DSO is for-profit and open, that is, it sells shares to the public, then several economic issues must be considered. The DSO's earnings per share becomes important. If it is low, the share price will fall and the total equity value of the DSO will decline. If the earnings per share increases, the share price and the total equity value of the DSO also will increase, due to both the existing shares' increase in price and the issuance of new shares. If the DSO is dentist-owned and closed (shares are not offered for sale), it is evaluated more like a large independently owned group practice.

Secondly, the equity owners of a dental corporation may or may not record a salary. If they are paid a salary, this can be written off as an operating expense. This applies to dental corporations in general, whether they are large group organizations with nondentist ownership, large group organizations owned by dentists, or typical small independent corporations with one or two practice locations.

As a general rule, the greater the EBITDA, the more business the organization is doing—but it may not be a very good investment. Suppose a DSO generated $20 million EBITDA and had 100 equity owners. Then each equity owner's share would be $200,000 in equity income, whether or not it was distributed to the 100 individuals or retained by the corporation. Compare that return to a DSO that generated $10 million EBITDA and had 10 equity owners. Then each owner's share would be $1 million. There is no reliable correlation between EBITDA and distributed income; a company can have a high EBITDA but little or no after-tax income. Another fact to keep in mind is that a shareholder generally has no right to distribution; only the board of the corporation can vote a dividend.

Another market approach is to consider the book value of a DSO in relation to the equity it generates. Suppose one DSO generates a dollar of equity income for every $1 million dollars in book value and the second generates a dollar of equity for every $2 million in income. Which is the best investment? Again, it depends on one's assessment of the corporation's ability to grow equity return in relation to book value.

VII. FINDINGS

A. Assessment of Key Attributes

For the purpose of this report, the six management companies, labeled A through F, were assessed on 18 distinct criteria, as set forth below. Generally, in all these models, dentists enter the structure as associates or employees. Some models offer the possibility of advancement to owner, but that position comes with different degrees of practice control in different models. Additionally, every model utilizes a centralized management philosophy or protocol, applicable to all associates and practices. However, that's where the commonalities appear to stop.

Corporate Dentistry Models	**A**	**B**	**C**	**D**	**E**	**F**
Provision of Business/Practice Management Services						
Internal to each practice						
Internal but centralized among multiple practices				X		
External through a business services agreement with a business services company	X	X	X		X	X
Ownership of the Business Services Company						
Board of directors	X	X	X	X	X	X
Dentist shareholders–equal shares				X		
Dentist shareholder(s)–one or a few majority controlling shares						X
Nondentist investors (equity firms)	X	X	X		X	
Chief executive–dentist	X	X	X	X		X
Chief executive–nondentist					X	
Ownership/Control of Practice by Dentist (PC Owner/Shareholder)						
Owns patient records	X	X	X	X	X	X
Owns building						
Owns equipment						
Purchases supplies (choice of vendor/quantity)				X		X
Roles of Dentists						
Associates/employees	X	X	X	X	X	X
Owner of professional corporation	X	X	X	X	X	X
CEO of business corporation	X	X	X	X	X	X
Shareholders				X		
Board of directors				X		X

Corporate Dentistry Models

Corporate Dentistry Models	A	B	C	D	E	F
Role of Equity Firm(s)						
None				X		X
Majority ownership	X		?		X	
Minority ownership		X	?			
Short-term holding (buyout within five years)	X		?			
Long-term holding (buyout after five years)		X	?		X	
Professional Corporation						
One PC per state	X	X		N/A		
Multiple PCs per state						X
One PC for multiple states					X	
PC owned by dentist	X	X	X	N/A	X	X
PC owned by nondentist						
PC has business services agreement with external business services company	X	X	X		X	X
Education/Support for Organized Dentistry						
Provides internal continuing education (CE)		X		X	X	?
Reimburses for external CE (ADA, AGD, vendors)				X	X	X
Program Approval for Continuing Education (PACE) approved?	Y	*	*	Y	N	Y
Promotes ADA membership				X	X	
Promotes AGD membership				?		
Quality Assurance						
By the PC/PC owner, who is a dentist (or board of dentist owners)	X			X		X
By the PC/PC owner, who is not a dentist						
By the business services corporation				N/A		
By the non-PC owner, a practicing dentist						
By a hygienist or other support staff						
Initial review by dentist(s) to report to nondentist(s) for final determination					X	
Target Patient Demographic						
Medicaid					X	
Uninsured				X	X	X
Insured				X		X
Children					X	
Adults					X**	
Business Services Agreement						
No business services agreement with external company				X		
Fixed-fee business services agreement		X				
Percentage of revenue for business services agreement					X	X

** B and C have study clubs that are PACE-approved CE providers; however, the parent companies are not PACE approved.*

*** D has a second brand contracted with a parent company that provides care to adults.*

Corporate Dentistry Models	**A**	**B**	**C**	**D**	**E**	**F**
Revenue Generation						
Increasing revenue within individual practices	X	X		X	X	X
Increasing number of practices	X	X		X	X	X
Wall Street valuation/sale–multiple of EBITDA	X	X			X	
Recruitment						
Students						X
New graduates						X
Experienced dentists						
Marketing						
To the profession (ASDA, AGD, ADA)						X
To the public					X	
Uses practicing dentists						X
Uses business professionals					X	
Growth Incentives for Dentists						
Rewards tied to performance–patient health outcomes						
Rewards tied to performance–production/collection						
Career path from employee to PC owner						X
Career path from employee to shareholder/board member				X		
Revenue Goals						
Based on collections (e.g., monthly practice revenue)						X
Based on production (e.g., number of patients seen per day, procedures completed per day)					X	
Not directly tied to revenue goals				X		
Existence in States That Prohibit Nondentist Ownership						
Exists in states that prohibit actual ownership	X	X	X	X	X	X
Refrains from entering certain states based on allowances of the law					X	
Independent Midlevel Providers						
Support						
Oppose						
Indicated that they would be useful in the model					X	
PPACA Advocacy						
Relationships with payers				X		
Relationships with legislators				X		
Relationships with integrated health systems (medical)				X		
Advocacy to increase Medicaid fees/other fed					X	

While numerous variations exist among these companies' models, the investigation nonetheless revealed three overarching structures that would fall within the definition of corporate dentistry presented above.

B. Three Overarching Structures

DSO with internal management (Model D)

In this model, the practices' dentist owners are also the sole shareholders of the DSO. The governance structure similar to that of a professional association; the shareholders may elect a board, which then sets policy, determines budgets, and establishes the common mission, vision, values, and guidelines/protocols.

This model seeks to maximize each practice's revenue by providing practice management relief through not only some shared office management services, but also the aforementioned shared internal management guidelines and protocols.

Unlike the other models (DMSOs) discussed further in this report, a DSO with internal management does not utilize a business services agreement, since the dentist owners are the shareholders of the corporation and elect the board that develops their policies. This model emulates the functionality of a professional association such as the AGD; members do not require a business services agreement to access their membership benefits, because they, through their delegates and their elected board, are ultimately the "owners" of the AGD.

Under this model, production goals (revenue or number of patient seen) are set by the practicing dentist owners. As a result, practices using this model are not particularly distinguishable from many large traditional practices. Further, with no outside contract and revenue goals that are in line with the traditional goals of a dental practice, owner dentists appear to have final control over employment decisions, equipment use, supply purchases, and other business decisions.

DMSO without *outside equity ownership (Models A and F)*

There appear to be numerous concepts within the dental management services model (DMSO), aka MSO/DSO (or simply "DSO").

First, an MSO cannot exist without a DSO component, but a DSO can exist without an MSO when the DSO has its own internal management system, as in Model D.

The DMSO without outside equity ownership model presents a group of PCs that has no internal management, but does have a business services agreement with a single third-party MSO.

In this model, instead of being owned by outside equity investors, the MSO may be owned by one or more individuals, who may be dentists or nondentists.

Unlike the DSO with internal management model, the party in this model with primary revenue interest is not the same party or parties with the primary clinical interest. Therefore, Models A and F utilize productivity goals that are ultimately driven by the MSO rather than by the DSO, even if they are implemented or varied in implementation by the DSO.

However, this model is also distinguishable from the DSMO with outside equity ownership model in that the profitability of the company is based entirely upon business services agreement fees, which vary directly with each practice's revenue stream and are not tied to any Wall Street valuation in preparation for sale of the MSO.

DMSO with *outside equity ownership (Models B, C, and E)*

Although this model similar to the previous model, its distinguishing factor is the ownership of the MSO.

The extent of equity ownership may vary by DMSO. However, where there is outside equity ownership, the equity firm's interest is in maximizing the enterprise value of the acquisition in order to make it most attractive for sale. Enterprise value is the present value of future cash from business operations reflected as a multiple of EBITDA or EBITA to reflect the growth expectation of the acquisition in the industry. Solely using an enterprise value may result in the exclusion of services costs (i.e., supply/equipment costs) and actual administrative and overhead expenses. That is, while the exclusion of taxes and interest provide for better comparison between companies in the same industry, it may also paint an unrealistic picture of the company's value by including only present value of current and future business operations.

When dealing with business modalities whose primary services are business services for dental practices, repeatedly inflated valuations over the course of multiple sales may create a market "bubble," unless overhead costs are fully driven by the need to avoid an inflated valuation rather than the needs of dentistry.

Our findings support this assessment. Models B, C, and E drive revenue/production expectations; control the vendors used, the quantity of supplies, and the equipment utilized; and sometimes exercise final approval on employees hired. That is, the drive to maximize enterprise value is inherently at odds with the provision of quality of care, and it is unclear how to bridge this gap for the benefit of both over a sustainable long-term future, without "bursting the bubble," so to speak.

C. Growth of the Corporate Practice of Dentistry

The findings vary regarding corporate dentistry's growth rate. While some economists expect continued growth of large group practices, including models of corporate dentistry, others predict that the market share of corporate models has reached a plateau or will reach a plateau at or about 20 to 25 percent of all practice modalities.

The Dental Group Practice Association (DGPA), an organization of DSOs, estimates a compound annual growth rate (CAGR) of 30 percent per year over five years (2010 to 2015) for its member DSOs, versus a 6.75 percent CAGR for the dental industry as a whole.

The ADA estimated in 2009 that large group practices would have a 11.2 percent market share in dentistry by 2015, in contrast to the 3 to 5 percent share (varies by report) of corporate dentistry in today's market.

However, the growth of these modalities also may depend greatly upon the demands of the market.

First, because of the inherent conflict between maximizing enterprise value and satisfying overhead costs, and the ethical obligations of dentistry, equity-backed DSMOs may not be able to avoid "bursting the bubble"—especially in light of an investigation by U.S. senators that found the intrusion of a specific equity-backed DMSO into the clinical practice of dentistry adversely affected patients.

Second, the implementation of health care exchanges and, moreover, the enforcement of essential health benefits, which include pediatric dental services but not adult dental services, appear to be driving DSOs toward a focus on adults who fall between Medicaid-eligible and employer-insured, in an effort to capitalize on the PPACA for increased long-term relevance in the industry.

D. Motivations for Joining Corporate Modalities

While equity-backed DSMOs focus their marketing efforts on the public, DSOs and DSMOs that are not equity-backed appear to focus their marketing efforts on professional dentistry, including the ADA, AGD, and American Academy of Pediatric Dentistry (AAPD).

According to the results of the ADA's Group Practice Survey of 2012, dentists' reasons for joining corporate dentistry include work-life balance, interactions with other dentists, flexible schedule, guaranteed salary, and less interaction with insurance companies. These reasons far outweigh student loan debt.

Based on its research and discussions with parties of interest, the task force also identified several key factors that may play a role in the growth of corporate dentistry. These may include lack of leadership, practice ownership, and practice management training in dental schools, including education on practice laws and regulations. Notably, dental schools appear to provide as little as six hours of practice management training, while DSOs provide new associates with 100 to 200 hours of CE. While much of that CE appears to be training in clinical efficiency of high-revenue procedures, some of it also appears to cover practice management.

Unpublished data from a July 2009 survey by the ADA's Health Policy Resources Center on Large Group Practices also indicated that, while 12.7 percent of dentists who practice in large groups are between the ages of 30 and 39, another 32.5 percent of them are 40 or older. Therefore, the appeal of large groups, including corporate dentistry settings, is not limited to new graduates or young dentists.

A dentist who owns a traditional practice has to wear many hats—CEO, human resources manager, chief financial officer, clinician, and his or her own employee. Some corporate models claim to offer the opportunity for improvement by allowing dentists to focus only on clinical treatment. Corporate dentistry also allows dentists to gain cash-out value for their practices while continuing to practice dentistry.

Behind the varying drivers mentioned, including the economic downturn, the central demand in the profession seems singular: practice management relief. In fact, many of the factors identified by the results of the ADA's 2012 Group Practice Survey—work-life balance, flexible schedule, guaranteed salary, and less interaction with insurance companies—also appear to be perceived benefits of relief from some of the time and effort spent on managing a traditional solo practice or partnership.

Moreover, a review of the rise and strategies of the various group practice models and consulting companies led to similar findings. Regardless of the strategies or the challenges they cite, the solutions they may offer, or the financial windfall they may seek, the perceived demand or opportunity these companies seek to address, resolve, and/or capitalize on, is the same: practice management relief.

E. State Laws and Regulations

No state allows the practice of dentistry by a nondentist. More than 70 years ago, a federal court (U.S. v. American Med. Ass'n, 110 F.2d 703, 714 (D.C. Cir.1940)), held that "where a corporation operates a clinic or hospital, employs licensed physicians and surgeons to treat patients, and itself receives the fee, the corporation is unlawfully engaged in the practice of medicine. This is true because it has been universally held that a corporation as such lacks the qualifications necessary for a license, and without a license, its activities become illegal." This decision, as applied to dentistry, prohibits a nondentist corporation from receiving fees for the provision of dental services that are sanctioned to be in the scope of licensed dentists.

Recently, a California appellate court expounded upon this concept (Steinsmith v. Med. Bd., 85 Cal. App. 4th 458, 462 (Cal. App. 2000)) by explaining that the "ban on corporate practice is intended to prevent interference with the physician-patient relationship by a corporation or other unlicensed person and to ensure that medical decisions are made by a licensed physician. … [T]he physician should not be forced to choose between the dictates of his or her 'employer' and the best interests of the physician's patients. It is this potential for divided loyalties … that the bar against corporate practice is intended to prevent."

The issue arises today, however, in state laws regarding business services agreements (or contracts) that are so intrusive as to give nondentist corporations (or nonlicensed dentist corporations) effective control over the clinical practice of dentistry.

According to the law offices of Moriarty Leyendecker, in its "Survey of State Laws Governing the Corporate Practice of Dentistry" (2012):

*"Courts have recently voided contracts between dental management companies and dentists under the laws of several states because the arrangements gave the companies broad control over how the dentists cared for patients and effectively allowed the companies to practice dentistry without a license. See, e.g., In re OCA, Inc., 552 F.3d 413, 422-423 (5th Cir. 2008) (Texas law); OrthAlliance, Inc. v. McConnell, 2010 WL 1344988 at ** 3-4 (D.S.C. 2010) (South Carolina law); OCA, Inc. v. Hodges, 615 F. Supp. 2d 477, 481 (E.D. La. 2009) (Pennsylvania law); Amason v. OCA, Inc., 2009 WL 361070 at * 4 (E.D. La. 2009) (Alabama law); Mason v. Orthodontic Ctrs. Of Colorado, Inc., 516 F. Supp. 2d 1205, 1216-17 (D. Colo. 2007) (Colorado law); Orthodontic Ctrs. of Illinois, Inc. v. Michaels, 403 F. Supp. 2d 690, 695 (N.D. Ill. 2005) (Illinois law). … Six states—Arizona, Mississippi, New Mexico, North Dakota, Ohio, and Utah—permit practice by business corporations, some form of ownership by non-licensees, or corporate employment of dentists. Two states—Michigan and Nebraska—have no statutes or recent case law directly addressing corporate practice. Two others—Kentucky and Wisconsin—have conflicting or unclear statutory or common law regimes, making it difficult to determine their current limits on corporate practice. Iowa forbids corporate practice but may permit business corporations to employ dentists if they do not influence care or more generally practice dentistry. All of these states, however, prohibit corporate and non-licensee interference with dentists' independent performance and clinical judgment. As a result, a business corporation or unlicensed corporate manager who, for example, dictated use or avoidance of particular procedures or limited the length of time dentists can spend with individual patients would be violating these and every state's laws. All other states and the District of Columbia clearly prohibit corporate practice."*

Note, however, that courts have distinguished PCs owned by dentists licensed to practice in the state(s) from business corporations, whereby the PC may employ dentists to provide health care and derive a financial benefit from the provision of care.

VIII. CONCLUSIONS AND TAKEAWAYS

The AGD reiterates that, regardless of practice modality, the ultimate responsibility for compliance with state laws and regulations falls upon the practicing dentist.

However, the responsibility of each practicing dentist does not alleviate the responsibility of each state to ensure that its laws and regulations enable dentists to practice in the best interest of their patients—without forcing them to choose between their job and their ethical obligations to the profession.

According to the task force's findings, states do not need to create revolutionary laws, but rather simply review and revise existing laws and regulations as needed to ensure that business services agreements do not, directly or indirectly, transfer clinical decisions to one who is not a licensed dentist in the state. The indirect transfer of clinical decisions could result from provisions that place necessary clinical decision-making for optimal patient care in conflict with business protocols for continued employment or receipt of income.

Corporate practices in dentistry that comply with state laws and regulations that have been reviewed and updated to enforce current restrictions against the practice of dentistry by those who are not licensed dentists are functional modalities of dental practice.

The findings of this investigative report indicate a need for additional and ongoing detailed studies on models of dental business valuation and corporate practice, as laws, regulations, payment and insurance methodologies, economic climates, and dentists' priorities continue to evolve.

Moreover, according to AGD's 2013 Membership Dental Practice Survey, 5.4 percent of AGD members work in settings that would fall within the classification of corporate dentistry as defined in this paper.

The profession of dentistry first and foremost is focused on the best and most appropriate care of patients. It is important to ensure that no practice

modalities or treatment criteria interfere with the dentist-patient relationship, appropriate treatment decisions, and the delivery of care. It is also important for the profession of dentistry to support its peers who provide excellent, appropriate, and ethically delivered care, regardless of the setting in which that the care is delivered.

A dental organization should educate the profession, both students and practicing dentists, and advocate for the profession by supporting legislation that protects the practice of dentistry by licensed dentists for the optimal care of patients.

The complexities of contracts and business models, as well as their potential for far-reaching implications, make a full and clear understanding of all the elements of practice that much more important.

This investigation revealed that, while dentists ask questions, many do not ask the right questions. Dentists, especially new graduates, often ask what their hours might be or how much they might get paid. However, interviews indicated that dentists are not asking but should ask the following questions, among others:

1. Who is my employer?
2. Who can create or edit a treatment plan? Who is responsible for the treatment plan? Do I have the authority to disagree with or change a treatment plan?
3. Who owns the dental professional entity? Who owns the business entity?
4. What is the governance structure of the dental professional entity? Of the business entity?
5. Does the business entity have a relationship with any outside investors, such as an equity firm or public company?
6. Is there a management services agreement? If so, does that agreement comply with state laws?
7. What my employer's expectations regarding my productivity, patient volume, and revenue? For example, may I take two hours to complete a crown prep?
8. What formula is used for dentist compensation? That is, to what degree is my remuneration based on my productivity?
9. What is the relationship between my compensation and that of the business entity?
10. Who is owns the lease agreements for the building? For the equipment? If I buy a practice, will I have the opportunity to own the equipment in full, or will I rent the equipment perpetually? If I can own the equipment, what is the lease term, and is there a separate agreement for a lease-to-own opportunity?
11. May I use any vendor for supplies? Is there a cap on the volume or type of supplies available?
12. May I use a dental laboratory of my choosing? How are lab costs ascertained and apportioned?
13. Who has control over revenue stream distribution, and how is the revenue stream distributed?
14. Who owns the patient records? Upon termination, would I have access to the patient records? If so, to what extent? Is there a procedure for accessing these records?
15. How are after-hours emergencies addressed?
16. Who makes hiring and firing decisions? Are there any protocols or guidelines for these decisions?
17. May I have access to all contracts and other documentation upon which the above answers are based, so that I may share them with an independent attorney, accountant, or professional adviser?

Ultimately, the findings highlight how important it is for a dentist to access the information necessary to determine whether management services could impinge upon the dentist's ability to exercise his or her professional clinical judgment, and to comply with the ADA Principles of Ethics and Code of Professional Conduct, as well as state and federal laws and regulations.

Regardless of who holds the responsibility for business decisions, dentists hold the responsibility for their clinical and ethical decisions, whether before a state dental board, a court of law, or the court of public opinion.

Therefore, the findings suggest that all dentists, from new graduates to established practitioners, should gather the necessary information and consult with their own independent attorney or accountant, or another professional who is familiar with the various modalities of business practices in health care delivery, before making a career decision—regardless of which practice modality they are considering.

REVIEW OF ADDITIONAL LITERATURE

Following are a few of the sources, in addition to interviews and sources discussed above, that the Practice Models Task Force reviewed prior to development of this investigative report.

Please note that the following sources were not determinative of the task force's findings. Rather, they were considered as informative of the current debate on corporate practice models.

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4. Carol Treiber, et al. v. Aspen Dental et. Al., L.P.,Case 3:12-cv-01565-DNH-ATB (NY, October 18, 2012).
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12. Dollars and Dentists. Frontline, PBS, website: http://www.pbs.org/wgbh/pages/frontline/dollars-and-dentists/. June 26, 2012.
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16. Byron Harris (reporting), News 8 stories prompt legislation to curb Medicaid abuse. Website: http://www.wfaa.com/news/investigates/Stories-Provoke-Legislation-187212471.html. January 16, 2013.
17. Texas tries to crack down on dental chains that put profits ahead of patients. Website: http://www.publicintegrity.org/2013/01/07/12003/texas-tries-crack-down-dental-chains-put-profits-ahead-patients. January 7, 2013.
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19. Byron Harris (reporting), Undercover camera captures Medicaid Dental payment. Website: http://www.wfaa.com/news/investigates/medicaid-dental-payments-184051411.html. December 18, 2012.
20. AAPD President says it's possible for low income children to get good dental care. The Today Show. Website: http://www.today.com/id/26184891/vp/50165611#50165611.
21. Byron Harris (Reporting), The Darkest Side of Medicaid Dental. Website: http://www.wfaa.com/news/investigates/Tempt-and-Torture-The-darkest-side-of-Medicaid-dental-183282861.html. December 12, 2012.